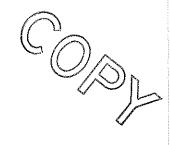


HEALTH & WELFARE



C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBBY RANSOM, R.N., R.H.I.T - Chief BUREAU OF FACILITY STANDARDS 3232 Eider Street P.O. Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

October 28, 2008

Steve Silberberger Seven Oaks Community Homes - Knapp East 3940 West 5th Avenue #C Post Falls, Idaho 83854

RE:

Seven Oaks Community Homes - Knapp East, Provider #13G076

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Knapp East, which was conducted on October 23, 2008.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MÍCHAEL A. CASE

Health Facility Surveyor

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

MC/mlw Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FEAR OF CORRECTION			A. BUILDING		G		
13G076		B. WING			10/23/2008		
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - KNAPP EAST				2	REET ADDRESS, CITY, STATE, ZIP CODE 804 KNAPP CIRCLE POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	SHOULD BE COMPLETION	
W 000	INITIAL COMMENTS		W 000				
	the requirements of Conditions of Partic	op East is in compliance with f 42 CFR 483 Subpart I, cipation: Intermediate Care ns with Mental Retardation.					
	The survey was co Michael Case, LSV	nducted by: V, QMRP, Team Leader					
,	p.		***************************************				
ADORATOR	V DIDECTOR'S OF PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	MATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 13G076

FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 13G076 10/23/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2804 KNAPP CIRCLE SEVEN OAKS COMMUNITY HOMES - KNAPP E POST FALLS, ID 83854 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) M 000 M 000 16.03.11 Initial Comments Seven Oaks - Knapp East is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)." The survey was conducted by: Michael Case, LSW, QMRP, Team Leader

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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